Back in the Hospital Again? Transitional Care and Coaching Initiatives
Current System Challenges

- Unsustainable Medicare spending
- High costs and poor outcomes
- Current Health Care Delivery System is fragmented
- Growing number of patients with multiple chronic conditions
- Care Coordination Burden is going unaddressed

HealthCare Advisory Board
Health Care System is an Oxymoron

- Multiple providers
- Inconsistent medical management
- Narrow perceived accountability
- Lack of systems to bridge transitions
- No common medical record

Naylor
“System” is Fragmented

- A PCP seeing 257 Medicare patients/year has a network of 183 peers in 108 different practices

- A Medicare patient sees 2 PCPs and 5 Specialists in 4 different practices a year
“Perfect Storm of Patient Safety”

Discharges are:

- Non-standardized
- Frequently marked with poor quality
  - Loose Ends
  - Poor preparation
  - Fragmentation
  - Great variability
- Which leads to a Rush to Discharge….Gaps in communication….and medication and other medical errors

Manasseh, Project RED

Levine
A Single Event at the End of a Hospitalization

Discharge means:

- Dismiss
- Detonate
- Expel
- Eject
- Set Free

We’re Done!
Requires Significant Cultural Changes

- Each profession and setting has its own language, norms and unspoken rules
- In each setting family roles are different and are seldom explained
- Little information, involvement and training for family caregivers

Levine
Patients experiencing medical errors related to discontinuity of care

Follow up care between discharge and readmission is often missing

Almost 50% did not have an MD appointment within 30 days of hospital discharge  Jencks
Fundamental Flaw

Readmissions are:

- A failure of the healthcare system
- A symptom of a fundamental flaw in our system
- Seen as waste
- A patient safety issue
Why Target Readmissions

- Readmissions have emerged as a priority of national scope
  - Almost 1 out of every 5 Medicare FFS discharges (19.5%) are readmitted within 30 days
  - 34% of discharges were readmitted within 90 days
  - Estimated annual cost to CMS = $17.4 Billion
- A growing number of provider-level, community, regional, state and national efforts are now specifically focused on reducing avoidable re-hospitalizations.

Penalizing Lack of Coordination

- Penalizing lack of coordination by penalizing readmissions….even though hospital isn’t responsible
- Pt’s are getting more complicated
- Patients arrive at our hospitals with poorly managed chronic care conditions
From the 2nd World Congress on Readmissions

- Diagnoses do not define risk for readmission.  Arbaje
- Most older adults don’t come back for the same diagnosis
- Functional and Cognitive Impairment and Lack of Social Support determine risk
- **Focus on frailty and risks over and above their diagnosis/condition**
- Poor transitional care is especially dangerous for older adults and those with complex, chronic illness
- If you have a transition in the past, you are at highest risk for another transition
Hospital to Home Care is the riskiest transition.

Transactions Associated with ED Visits and Preventable Hospitalizations

- Hospital to Home Care: 14.2
- Home to Nursing Home: 10.1
- Nursing Home to Home Care: 9.3
- Rehab to Home Care: 8.5
- Hospital to Nursing Home: 8.1
- Home Care to Nursing Home: 7.6

Mean # Problems per 100 Transactions
Transitional Care

A set of actions designed to ensure the coordination and continuity of health care as patients transfer between different locations or different levels of care within the same location.

- Logistical arrangements
- Patient/caregiver education
- Coordination among the health professionals
Transitions of Care

- The movement of patients from one health care practitioner or setting to another as their condition and care needs change
- Occurs at multiple levels

Within Settings
- Primary Care
- Specialty Care

Between Settings
- Hospital
- Sub-Acute Facility

Across Health States
- Curative Care
- Palliative Care
## Evidence-Based Interventions

<table>
<thead>
<tr>
<th>Initiative</th>
<th>PCP Handoffs</th>
<th>Follow-up Appointments</th>
<th>Post-Discharge Phone Calls</th>
<th>Home Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care Transitions Intervention (Coleman)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Project RED (BMC)</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>Transitional Care Model (Naylor)</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>Project Boost (SHM)</td>
<td>✔️</td>
<td>✔️</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Hospital to Home

A Local Transitions of Care Model
YEARS of conversation

Practice Change Fellows Program

Feasibility pilot conducted with Sheltering Arms Senior Services and The Methodist Hospital

Planned expansion to Care for Elders partners
H2H Interdisciplinary Dream Team

- **Medical/Health Care**
  - Aanand Naik, MD

- **Pharmacy**
  - David Putnam, PharmD

- **Social Work**
  - Lynda Collins, LCSW
  - Nancy Wilson, LMSW
  - Jan Edwards, LCSW
  - Gloria Berendzen, LCSW

- **Nursing**
  - Ellen MacDonald, RN
  - Sue Fox, GNP

- **Health Care Administration**
  - Kelley Moseley, PhD
Target Population

- Older adults w/admitting diagnosis of congestive heart failure (50 and older)
- Discharge to home (other than a nursing home)
- Residents of Harris and parts of Ft. Bend, Brazoria, and Galveston Counties
- English speaking
- Could be reached at home by phone
Core Elements of H2H

- Coleman’s Four Pillars and Client Empowerment Approach
  - Medication management
  - Personal health record
  - Physician and specialty care follow-up
  - Knowledge of red flags
- Social worker as transitions coach
- Case management – attention to psychosocial needs
- Healthy IDEAS – depression intervention
Protocol

- Day 1 Post Discharge – 1\textsuperscript{st} Contact
- Day 2 Post Discharge – Initial Home Visit
  - Cognitive Assessment
  - Medication Reconciliation
  - Personal Health Record
  - Education/Reinforcement re: Red Flags
  - Initiate Healthy IDEAS
- Weekly for 90 days - home visit or telephone contact
- Monthly, for as long as needed – home visits and telephone contacts
Tools

- Client Assessment and Care Plan Forms
  - Geriatric Depression Scale (GDS)
  - Kansas City Cardiomyopathy Questionnaire – quality of life measurement tool
- Medication Reconciliation Forms
- Personal Health Record
- CHF and Red Flags Educational Materials
- Weight and Blood Pressure Monitoring Chart (for clients)
Preliminary Evaluation Results

- 2 readmissions within 30 days of discharge (N = 27)
- Statistically significant improvements in quality of life scores
- 67% felt more confident that they knew what to do and whom to call (N = 21)
- Clinically and statistically significant reduction in depression for 5
Case Example - Mr. Jones

- Married
- 64 Years Old
- Newly diagnosed with Congestive Heart Failure
- Also has Diabetes and Kidney Disease
Mr. Jones at Home

- Cannot work due to chronic disease
- Wife provides sole financial support
- Does not qualify for assistance due to wife’s income
- Depression score on GDS is 13 (Scale 1 to 15)
Four Pillars

For Mr. Jones
Medication Management

Situation
- Medications – keeps bottles on his dresser
- Takes at different times of the day
- Medication Reconciliation – showed two possible interactions

Transition Coach
- Reinforced importance of adherence to a regime
- Purchased pill reminder box
- Provided education about interactions

Progress
- Client followed up with doctor
Symptom Management

Situation
- Client does not call doctor when symptoms are first noticed
- Goes to ER when symptoms are life threatening
- Client understands symptoms and disease

Transition Coach
- Provided symptom guide that details symptoms and appropriate responses
- Provided symptom chart to record weight and blood pressure
- Role played with client about talking with the doctor
Follow-up on Doctor’s Appointments

Client Scheduled and Maintained Doctor’s Appointments
Personal Health Record

Situation
- Does not have medical history and information in one place
- Does not maintain a current list of medications
- Hesitant to ask doctor questions – “He’s too busy.” “I forget what I wanted to ask.”

Transition Coach
- Provided Personal Health Record booklet
- Educated about how to use PHR

Progress
- Client completed and maintained PHR
During The Program

- Wife separated from client
- Wife gave notarized statement that she would not provide assistance
- Client was hospitalized for depression
Transitions Coach
Additional Interventions

- Healthy IDEAS and counseling for depression

- Utilized Care for Elders Flexible Funding Pool to purchase:
  - Emergency groceries
  - Utility assistance
  - Doctor and medication co-pays
  - Transportation to the doctor

- Assisted client in applying for:
  - SSI
  - Social Security Disability
  - VA Disability
  - Food Stamps
  - CEAP (utility assistance)
  - METRO Lift
  - Handicap Placard
Mr. Jones at Home Today

- SSI check coming monthly
- Food Stamps
- CEAP utility assistance
- VA disability is pending
- METRO lift
- No hospitalization for CHF in the first 30 days
- Quality of life improved
- GDS score at end of program: 1
Client Barriers to Participation in Hospital to Home

- Fear of losing independence and control
- Learned helplessness
- “Lost Voice”
- Patient Temperament
What helped?

- Motivational interviewing
- Goals that were tied to the intervention
- Personal contact by the Transitions Coach
Mr. Jones Said

“I don’t know what I would have done if it weren’t for you.”
Transition Coach Says

“I don’t know what he would have done without the Hospital to Home program”
Jane Bavineau  
Executive Director, Care for Elders  
Vice President, Sheltering Arms Senior Services  
jbavineau@shelteringarms.org  
713-685-6506  

Sheltering Arms Senior Services  
3838 Aberdeen Way  
Houston, Texas 77025  

References available at:  
www.careforelders.org